assist the recipient in accessing the services and perform monitoring and follow-up functions. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

A. **Intake and screening.** This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and indentifying potential payors for services.

B. **Assessment and reassessment.** During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. **Case management plan and coordination.** The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;

2. the continuity of service;

3. the avoidance of duplication of service (including case management services); and

4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the individual.

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D. **Implementation of the case management plan.** Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipients's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. **Monitoring and follow up.** As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. **Counseling and exit planning.** This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing linkages to support groups for the recipient, the recipient's family and informal providers of services; coordinating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

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An assessment provides verification of the individual's current functioning and continuing need for services, the service priorities and evaluation of the individual's ability to benefit from such services. The assessment process consists of those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS.**

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An assessment of the individual's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.** A written case management plan must be completed by the case manager for each individual receiving case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS.**

The individual's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the individual's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

a. those activities which the individual is expected to undertake within a given period of time toward the accomplishment of each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the individual will be referred;

d. the method of provision and those activities to be performed by a service provider or other person to achieve the individual's related goal and objective; and

e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

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3. **Continuity of service.** Case management services must be ongoing from the time the individual is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the individual; the recipient moves from the social services district*; the long term goal has been reached; the individual refuses to accept case management services; the individual requests that his/her case be closed; the individual is no longer eligible for services; or, the individual's case is appropriately transferred to another case manager. Contact with the individual or with a collateral source on the individual's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each OMH entity is not capable of serving individuals in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available, to the best substitute. Clients are free to choose among qualified providers within the State.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

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While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;

2. Medicaid eligibility determinations/redeterminations;

3. Medicaid preadmission screening;

4. prior authorization for Medicaid services;

5. required Medicaid utilization review;

6. EPSDT administration;

7. activities in connection with "lock in" provisions under 1915 (a) of the Social Security Act;

8. institutional discharge planning as required of hospitals, SNFS, ICFs and ICF/MRs;

9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan; and

10. representative payee services.

LIMITATIONS SPECIFIC TO TARGET GROUP "H"

In order to support a personal and proactive service, Supportive Case Managers will carry an average active case load of between 20-30 clients. Supportive Case Managers will see active clients a minimum of two times during a month. SCM employs a team approach to the provision of case management service. The inclusion of the SCM program in the service target group H will assure that the nature and intensity of services vary with individuals changing needs. These individuals may be referred to the SCM by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact.

D. **QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "H"**

1. Providers

The New York State Department of Social Services will authorize as Case Management providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations determined by State OMH and certified to SDSS to have the capacity to provide specialized Case Management Services and having written agreements with appropriate mental health providers and other human services providers.

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SCM Teams will vary in size and composition and may consist of one individual who may be a paraprofessional with adequate clinical supervision. Each supportive case manager must meet the minimum qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload. The qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload are the same. While supportive case management programs may provide services to individuals with only one staff member and a supervisor in the program, the more common model will utilize a team approach. The team may be comprised of professionals and paraprofessionals. All members of the team must meet the minimum qualifications for the SCM and will receive professional supervision, as detailed in this document. SCM teams will have a professional supervisor with both clinical and supervisory experience.

2. Case Managers

Minimum Qualifications for Supportive Case Manager:

Two years of experience in providing direct services or in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

a) one year of case management experience and an associates degree in a health or human services field; or

b) one year of case management experience and an additional year of experience in other activities with the target population; or

c) a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities with the target population; or

d) the individual meets the regulatory requirements for case manager of a State Department within New York State.

Minimum Qualifications for Coordinator of Supportive Case Management Services:

Education:

1. a master's degree in one of the below listed fields*

or 2. a master's degree in public administration, business administration, health care or hospital administration and a bachelor's degree in one of the below listed fields*;

or 3. NYS licensure and registration as a Registered Nurse plus a master's degree in 1 or 2 above

AND

Experience:

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Four years of experience:

1. in providing direct services to persons diagnosed with mental disabilities**;

or 2. in linking persons diagnosed with mental disabilities** to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing and financial services)

Two years of this experience must have involved:

1. supervisory or managerial experience for a mental health program or major mental health program component;

or 2. service as an Intensive Case Manager in a NYS Office of Mental Health registered ICM program.

*Qualifying education includes degrees in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing.

**The term "mental disabilities" refers to persons properly diagnosed with mental illness, mental retardation, alcoholism or substance abuse.

Minimum Qualifications for a Clinical Professional:

Clinical professional staff are individuals who are qualified by credentials, training and experience to provide supervision and direct service related to the treatment of mental illness and shall include: a credentialed alcoholism counselor; registered or certified creative arts therapist; certified nurse practitioner; licensed occupational therapist, physician, psychiatrist, psychologist, or registered professional nurse; registered physician's assistant or specialist's assistant; rehabilitation counselor with a Master's Degree in this field or current certification, pastoral counselor with a Master's Degree or equivalent in this field, certified social worker currently licensed or with a Master's Degree in this field, therapeutic recreation specialist who is registered or has a Master's Degree in this field.

Minimum Supervision Standard for Supportive Case Management Teams:

Supervision of the SCM team will be provided by the SCM Team Coordinator, or an appropriate clinical professional.

Routine review of tasks performed by the SCM team members will focus on enrollment, planning, and service linkage and advocacy. An SCM team meeting for case review will take place monthly or more frequently, if needed. Supervision of the SCM team members with paraprofessional job titles will be provided by a professional, who will be available at all times for consultation with the SCM and will provide direct supervision at frequent intervals to assure that recipient needs are being addressed. Supervision of paraprofessionals by a professional staff member will occur on a bi-weekly basis at a minimum and more frequently, if needed.

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Additionally, the coordinator will review each recipient case record with the SCM team members on a semi-annual basis at a minimum and more frequently, as needed. The SCM Coordinator will post a progress note in the record at the time of the case record review.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group:
See attached Target Group

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See Attached

State/Territory: New York State

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

See Attached